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ABSTRACT: State laws recognize that a competent adult patient has the right to consent to or refuse medical treatment. While the law is clear with regard to the right of competent adults, state statutes are more complicated when the patient is a minor. While the law should, and does, attempt to balance the rights and obligations of parents and guardians against the access and privacy rights of minors, complicated state statutory schemes often fail to simultaneously address those contrasting goals in a consistent and uniform manner. The result is a confusing set of seemingly arbitrary and sometimes conflicting provisions that require the detailed attention of healthcare providers to ensure legal compliance. With the aim of helping healthcare practitioners meet their legal obligations, this Article examines state laws governing minor's consent rights by focusing on the instances in which a minor's parent, guardian, or other authorized adult is permitted to consent to treatment on behalf of a minor and the instances in which a minor is authorized to act independent of adult intervention.

In 1914, Justice Benjamin Cardozo wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[1] Most states' laws recognize that proposition and reflect it in statutes and case law

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[1] Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds*.

governing consent to medical treatment. While the law is clear with regard to the right of competent adults to consent to or refuse medical treatment, state statutes generally are more complicated when the patient is a minor. While the law should, and does, attempt to balance the rights and obligations of parents and guardians against the privacy rights of minors, complicated state statutory schemes often fail to simultaneously address confidentiality concerns, public policy, and public health goals in a consistent and uniform manner. The result is a confusing set of seemingly arbitrary and sometimes conflicting provisions that require the detailed attention of healthcare providers to ensure legal compliance. Consequently, the interaction between the healthcare system and minor patients is often difficult because the healthcare provider may not understand when a minor patient may lawfully consent to treatment without the involvement of the minor's parent or guardian. Providers and their counsel need to understand the statutory schemes governing treatment of minors to ensure that minor patients receive the best care possible, as well as to ensure legal compliance and protect against potential liability.

Legal compliance is important because failure to obtain effective informed consent may give rise to a cause of action for battery based on the healthcare provider's intentional and unconsented touching of the patient.[2] Additionally, failure to obtain effective informed consent may breach the fiduciary duty that a physician owes to her patient and give rise to a malpractice action.[3] Thus, healthcare providers who fail to abide by applicable consent laws face potential civil liability.

The importance of recognizing when a minor may lawfully consent to treatment is also heightened by the fact that authority to consent to treatment generally invokes the minor's confidentiality rights.[4] With the recent emphasis on patient's rights and medical confidentiality, including implementation of the Health Insurance Portability and Accountability Act (HIPAA), healthcare providers and their counsel must pay particular attention to consent laws as they relate to confidentiality and privacy rights when a minor patient seeks treatment either independent of or pursuant to parental consent. Under HIPAA, a minor has authority to act as an individual on his

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[2] *See* Bommareddy v. Super. Ct., 272 Cal. Rptr. 246, 247 (Cal. Ct. App. 1990) (quoting Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972)), *overruled on other grounds by* Cent. Pathology Serv. Med. Clinic, Inc. v. Super. Ct., 832 P.2d 924 (Cal. 1992).

[3] *See Cobbs*, 502 P.2d at 9.

[4] 45 C.F.R. § 164.502(g)(2)–(3) (2002); *see* Cal. Health & Safety Code § 123105(a) (2004).

own behalf with regard to protected health information under three scenarios: (1) the minor consents to the healthcare services, no other consent is required by state law (regardless of whether it is obtained), and the minor has not requested that another person act as his personal representative; (2) the minor, under state law, may lawfully obtain the healthcare services without the consent of a parent, guardian, or other authorized person, and the minor, a court, or other authorized person consents to the services; or (3) a parent, guardian, or other authorized person assents to a confidentiality agreement between the healthcare provider and the minor with respect to such services.[5]

Thus, under HIPAA, a minor patient may have a confidentiality right in health information resulting from services to which the minor is authorized under state law to consent even if, in practice, the minor's parent or guardian actually gives consent. That right to confidentiality places many providers in the difficult position of determining whether a minor can independently consent to services even though the minor's parent or guardian actually gives lawful consent. For example, a parent may take his child to a physician for treatment of an infectious disease.[6] Even though the parent or guardian solicits and consents to services, HIPAA prevents the healthcare provider from disclosing protected health information to the parent or guardian if, under state law, the minor *could have* obtained those services independent of the parent or guardian and the minor has not requested that the parent or guardian be treated as the minor's personal representative.[7] Healthcare providers need to understand the limited scope of legal authority parents, guardians, and other authorized third parties have to consent to medical treatment[8] on behalf of a minor. Thus, in order to ensure HIPAA compliance, in tandem with understanding the role of parents and guardians, healthcare providers must also understand the instances in which a minor has legal authority to consent to treatment without the involvement of a third party.

[5] 45 C.F.R. § 164.502(g)(3)(i).

[6] *See* discussion *infra* Part IV.B.3.

[7] 45 C.F.R. § 164.502(g)(3)(i)(A). Of course, the provider can disclose protected health information to the parent with the consent of the minor.

[8] For purposes of this Article, the term "medical treatment" means medical or surgical diagnosis or treatment, including X-rays and anesthesia, and hospital care under the supervision of a licensed physician. *See* CAL. FAM. CODE § 6902 (2004). The term "medical treatment" and "healthcare" are used interchangeably.

This Article focuses on state statutes governing the interaction between minor patients and the healthcare system. The Article first explores the general legal and public policy background surrounding minors' interactions with the healthcare system. It then examines the role of parents, guardians, and other lawfully authorized adults to consent to medical services on behalf of a minor patient. The Article next reviews instances in which a minor may consent to medical services without the involvement of an adult. The consent rights of minors are discussed under two broad categories: instances in which the minor is deemed emancipated for healthcare decision-making and instances in which a minor may consent to treatment of a particular medical condition.

I. General Legal and Public Policy Background

As recognized by Justice Cardozo, competent adults have the right to consent to or refuse medical treatment.[9] That same right does not extend to minors, who generally are not considered mature enough to make informed healthcare decisions without the involvement of an adult. In most states, a "minor" is any person under eighteen years of age.[10] Absent an applicable exception, a healthcare provider may only provide medical treatment to a minor with the informed consent of the minor's parent, guardian, or other lawfully authorized third party.[11]

The fundamental public policy debate arising from allowing a minor to consent to medical services, versus requiring a parent or other qualified adult to give informed consent, focuses on the balance between respecting the privacy and confidentiality rights of the minor and providing unrestricted access to services, versus the rights and obligations of parents and guardians to care for their children and the need for a mature decisionmaker to be involved in the medical decisionmaking process. On the one hand, it seems

[9] *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds*.

[10] According to the Center for Health and Health Care in Schools, all states except Alabama, Nebraska, and Pennsylvania recognize eighteen as the age of majority for purposes of consenting to medical treatment. *See* Heather Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, The Guttmacher Report on Public Policy, Aug. 2000, at 7, *available at* www.healthinschools.org/sbhcs/papers/guttmacher.asp (last visited Sept. 5, 2004). In Alabama and Nebraska, the age of majority is nineteen and in Pennsylvania it is twenty-one. *Id*.

[11] *See, e.g.*, Del. Code Ann. tit. 13 § 707(b) (2003).

reasonable that a parent or guardian should not only be involved in making healthcare decisions for her minor child but that the law should emphasize parental responsibility and accountability for those decisions. To that end, parents may face prosecution for neglect or abuse for not seeking out and obtaining necessary medical care for a minor child.[12] On the other hand, certain circumstances exist in which the requirement for parental involvement may reduce the likelihood that a minor will obtain treatment, either because of a nonsupportive parent/child relationship or the sensitive nature of services sought. In such situations, the minor's physical wellbeing and need for services may take precedence over the requirement that the parent or guardian be involved in the decisionmaking process. Additionally, there may be cases in which the involvement of a parent or guardian is not in the best interest of the minor.

State laws attempt to balance these contrasting public policy concerns by requiring parental informed consent unless contravening factors exist. For example, emancipated minors, including minors who are "mature" though not legally emancipated, generally live independent of their parents and, thus, are authorized to consent to medical treatment without parental or other third-party authorization. Additionally, the law carves out specific types of sensitive and/or high-risk conditions for which a minor may consent to treatment on a confidential basis without parental informed consent or knowledge. The purpose of those statutory exceptions is to encourage treatment. For example, a minor may be uncomfortable seeking parental consent to mental health counseling services, particularly if the parent is the subject of the counseling. The law also allows a minor to consent to treatment of high-risk conditions that pose a significant danger to the minor and to public health if not treated. Such conditions include sexually transmitted diseases, including human immunodeficiency virus (HIV). Additionally, in some instances, state laws allow healthcare providers to exercise discretion and inform a minor's parent or guardian of treatment provided if deemed to be in the minor's best interest.

[12] *See, e.g.,* CAL. PENAL CODE § 11165.2 (2004).

II. The Authority to Consent to Medical Services

A. Consent Authority of Parents, Guardians, and Other Authorized Adults

Generally, a minor does not have authority to consent to medical treatment and a healthcare provider must obtain the informed consent of an adult who is authorized under state law to act on behalf of the minor for purposes of making healthcare decisions. Such authorized persons include the minor's natural or adoptive parent, a legal guardian, foster parent, or other authorized caregiver. In exceptional cases, a court may consent to medical treatment on behalf of a minor.

1. Natural or Adoptive Parents

For purposes of consent law, a minor's "parent" means "either parent if both parents have legal custody, or the parent or person having legal custody"[13] Absent a court order to the contrary, either natural parent may consent to medical treatment on behalf of a minor child.[14] That general rule applies regardless of whether the child's natural parents are married or divorced and whether the child is born in or out of wedlock.[15] Individuals who have legally adopted a child have the same consent rights as natural parents.[16]

[13] CAL. FAM. CODE § 6903 (2004); *see* MD. CODE ANN., FAM. LAW §§ 5-203(a)(1), 5-203(d)(1) (2004).

[14] *See, e.g.,* MD. CODE ANN., FAM. LAW § 5-203(b).

[15] *See* CAL. FAM. CODE § 7602. A court may award sole legal custody to one parent. *See id*. § 3006. In the case of a minor born out of wedlock, it may be difficult to prove paternity. If a healthcare provider has any doubt, the provider should ask for documentation, which may include a copy of the minor's birth certificate that includes the father's name.

[16] *See, e.g., id*. § 7601. California has adopted the Uniform Parentage Act, which governs the relationship of parents to their minor children. Other states have also adopted this act. ALA. CODE §§ 26-17-1 to 26-17-22 (2004); COLO. REV. STAT. §§ 19-4-101 to 19-4-130 (2004); DEL. CODE ANN. tit. 13 §§ 8-101 to 8-904 (2003); HAW. REV. STAT. §§ 584-1 to 584-26 (2003); 75 ILL. COMP. STAT. §§ 45/1 to 45/27 (2004); KAN. STAT. ANN. §§ 38-110 to 38-1138 (2003); MINN. STAT. §§ 257.51–257.75 (2004); MO. REV. STAT. §§ 210.817–210.852 (2004); MONT. CODE ANN. §§ 40-6-101 to 40-6-135 (2003); NEV. REV. STAT. §§ 126.011 to 126.371 (2003); N.J. STAT. ANN. §§ 9:17-38 to 9:17-59 (2004); N.M. STAT. ANN. §§ 40-11-1 to 40-11-23 (2004); N.D. CENT. CODE §§ 14-17-01 to 14-17-26 (2003); OHIO REV. CODE ANN. §§ 3111.01–3111.19 (2004); R.I. GEN. LAWS §§ 15-8-1 to 15-8-27 (2003); TEX. FAM. CODE ANN. §§ 160.001–160.763 (2004); WASH. REV. CODE §§ 26.26.011–26.26.913 (2004); WYO. STAT. ANN. §§ 14-2-401 to 14-2-907 (2003).

(Continued)

A healthcare provider may render treatment pursuant to the consent of either parent, and the provider does not need to seek the consent of both parents. In some cases, however, a minor's parents disagree as to the proper treatment for their child. Such disagreements often arise when the parents are divorced, separated, or otherwise acrimonious towards one another or when the suggested treatment is controversial. While both parents may have genuine concern for their child's wellbeing, their failure to agree on a medically appropriate course of treatment places the healthcare provider in a legally difficult situation. For example, parents may disagree with regard to cochlear implants for a deaf child or to similar controversial procedures that may or may not be in the child's best interest. While a healthcare provider who is aware of such a disagreement may lawfully proceed on the consent of either parent, a cautious approach requires that, in the absence of an urgent or emergent condition, the provider abstain from treatment until the parents come to agreement or, in extreme cases, one of the parents obtains a court order.

2. Guardians

Where a court has appointed a guardian for a minor, the ability of the guardian to consent to medical treatment depends on the scope of authority granted by the court and the type of treatment sought.[17] While a guardian may consent to ordinary medical care, a guardian may be statutorily precluded from consenting to nonroutine treatment. For example, California law provides that a guardian may not consent on behalf of a minor to placement in an inpatient mental health treatment facility, the administration of experimental drugs, convulsive treatment, elective sterilization, or psychosurgery.[18] Additionally, a guardian may not consent to surgery on a minor age fourteen or older without the additional consent of the minor or a court order.[19]

(Note 16 continued)

One area in which there is often confusion concerns the consent rights of stepparents. Unless a stepparent legally adopts a child, the stepparent does not, by virtue of marrying the child's natural parent, have any legal authority to consent to treatment on behalf of the child. While potential liability may be minimal when a healthcare provider renders routine treatment pursuant to the invalid consent of a stepparent, a provider should exercise diligence to ensure the authority of a stepparent when rendering higher-risk treatment. A stepparent may gain lawful consent authority either through legally adopting a child or through designation as an authorized caregiver, as is discussed below.

[17] *See, e.g.,* LA. REV. STAT. ANN. §§ 40:1299.51–40:1299.53 (2004).

[18] CAL. PROB. CODE § 2356 (2000).

[19] CAL. PROB. CODE § 2353(b) (2004).

When a healthcare provider renders treatment other than routine care to a minor under guardianship, the provider should document the authority of the guardian to give consent by obtaining a copy of the official certified letters of guardianship. The guardian should be able to produce the letters of guardianship without undue burden. If the guardian is unable to produce the letters of guardianship, the provider should contact the juvenile court to confirm the guardian's scope of authority.

3. Foster Parents

Licensed foster parents may consent to routine medical and dental treatment for minors placed with them pursuant to a court order or with the voluntary consent of the person having legal custody of the minor.[20] For other than routine care, a foster parent, or the healthcare provider who is called on to render services, should consult the juvenile court to determine whether the foster parent has authority to give consent. Nonroutine care may include non-emergent surgeries, elective procedures, and controversial or experimental treatments.

A healthcare provider should document the authority of a foster parent to give consent to medical treatment by obtaining a copy of the court order placing the minor in foster care. In most cases, the foster parent should either have or be able to obtain a copy of the court order without undue burden.

4. Authorized Caregivers

Adult, nonparent caregivers with whom a minor lives may also give consent to medical treatment for a minor.[21] This statutory device is useful when a child's parents are absent or deceased and the caregiver has not legally adopted the minor. For example, the situation often arises when a minor lives with his or her grandparents, or other relative, even though the minor's parents have not relinquished legal custody.

To qualify as an authorized caregiver, many states, including California and Delaware, require the adult caring for the minor to complete a Caregiver's Authorization Affidavit (Affidavit) or similar document.[22] The Affidavit has two functions. First, it may

[20] *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1530.6 (2004); N.J. STAT. ANN. § 30:4C-26.16(a).

[21] CAL. FAM. CODE § 6550 (2004); *see also* TEX. FAM. CODE ANN. § 32.001(a) (2004) (authorizing a minor's grandparent, adult sibling, or adult aunt or uncle to consent if the parent is not available).

[22] CAL. FAM. CODE §§ 6550, 6552; *see also* DEL. CODE ANN. tit. 13 § 707(b)(6) (2003) ("Affidavit of Establishment of Power to Relative Caregiver to Consent to Medical Treatment of Minors").

be used by an adult caregiver with whom the minor lives to consent to medical treatment necessary to enroll the minor in school. Second, the Affidavit may be used to allow an adult caregiver who is a "qualified relative"[23] of the minor and whom the minor lives to consent to any necessary medical treatment on behalf of the minor.

Under California law, a caregiver who wishes to consent to treatment necessary to enroll a minor in school (*e.g.*, immunizations and physical examinations) must complete a portion of the Affidavit, which includes providing the name of the minor, the minor's birth date, and the caregiver's name and address.[24] Additionally, the caregiver must affirm under penalty of perjury that the minor lives in the caregiver's home and that the caregiver is eighteen years of age or older.[25]

For a caregiver to be authorized to consent to general medical treatment for a minor, the caregiver must provide the same information that is required to consent to school-related medical treatment.[26] In addition, the caregiver must affirm under penalty of perjury that he is a qualified relative of the minor and that he has either: advised the parent (or other person having legal custody of the child) of his intent to consent to treatment and received no objection; or that he is unable to locate the parent or other person having legal custody.[27]

Execution of the Affidavit does not affect the rights of the minor's parents or legal guardians, and the Affidavit is valid for one year after execution.[28] A healthcare provider who relies on an Affidavit has no obligation to make any further inquiries or to investigate the truthfulness of statements contained in the Affidavit.[29] Additionally, any person who acts in good-faith reliance on an Affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated in the Affidavit, cannot be subject

[23] For purposes of California's authorized caregiver provisions, a "relative" is any one of the following: "spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half brother, half sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of such person even after the marriage has been terminated by death or dissolution." CAL. FAM. CODE § 6550(i)(2); *see also* DEL. CODE ANN. tit. 13 § 707(a)(3).

[24] CAL FAM. CODE §§ 6550(a), 6552.

[25] *Id.* § 6552.

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] CAL. FAM. CODE § 6552.

to criminal or civil liability or professional disciplinary action for such reliance.[30]

5. Third-Party Authorization

A third party who is not an authorized caregiver may consent to medical treatment of a minor pursuant to the written authorization of the parent or guardian.[31] To be valid, the authorization must be in writing and executed by the parent or guardian.[32]

Third-party authorizations are most commonly used when a child stays with a friend or relative for a short time. For example, parents may leave their child with a friend or neighbor for a day or two and provide the friend with a note that allows the friend to consent to necessary medical treatment while the parent is away. Alternatively, a third-party authorization can be used by a parent to allow another adult to take the child to a physician's appointment by providing written authorization applicable to that specific encounter. For example, a parent may write a note authorizing a friend to take a sick child to the doctor at a time when the parent is unable to attend the appointment.

Healthcare providers should rely on third-party authorizations only to provide routine medical treatment. Additionally, while not required by law, a provider should attempt to contact the parent or guardian prior to rendering non-emergent treatment pursuant to a written authorization if the written authorization is not specific to the encounter. The provider should document her contact attempts and, if applicable, document that the parent provided consent over the telephone. Of course, if the parent or guardian objects to treatment, the provider should abstain from providing any non-emergent services until the consent of the parent or guardian is obtained.[33]

6. Court Authorization

In rare instances, a court may stand in the place of a parent or guardian and consent to treatment of a minor. California law provides that a court may consent to treatment when a minor, at least sixteen

[30] *Id.*

[31] *See, e.g., id.* § 6910; TEX. FAM. CODE ANN. § 32.001(a)(5) (2004). *But see* DEL. CODE ANN. tit. 13 § 707(b)(5) (2003) (not requiring written authorization).

[32] California law provides that caregivers who are relatives may also authorize care if qualified under Section 6550. However, foster parents do not have statutory authority to execute a third party authorization. *See* CAL. FAM. CODE § 6910.

[33] Consent is presumed if the minor requires emergency medical services. *See, e.g.,* MASS. GEN. LAWS ch. 112, § 12F (2004).

years old, files an application with the court.[34] The court must find that the consent of the minor's parent or guardian is necessary for treatment to be provided and that the minor has no parent or guardian available to give consent.[35] Texas law provides that a court having jurisdiction over a suit affecting the parent/child relationship may give consent when the person having authority to consent cannot be contacted and has not given notice of objection to the treatment.[36] Similarly, Virginia law provides that a judge may consent to healthcare on behalf of a minor whose custody is within the control of the judge's court.[37]

III. Minors' Rights to Consent

The instances in which a minor has the right to consent to medical treatment without third-party involvement can be broken down into two broad categories. First, a minor who qualifies as emancipated, either by court order or on other grounds, may consent to medical treatment as if she were an adult. Second, an unemancipated minor may consent to treatment of specific types of conditions for which either the state legislature or the courts have granted such authority. Such authority applies to any minor who is capable of giving meaningful informed consent and who has the specified medical condition.

With regard to meaningful informed consent, it is important for healthcare providers and their counsel to acknowledge that even if statutory requirements for allowing a minor to consent to treatment are satisfied, the minor's consent will only be effective if the minor is mature enough to give truly *informed* consent. That means that the minor must be able to understand the nature of the treatment, risks and benefits of the treatment, the consequences of refusing treatment, and alternative treatments along with their risks and benefits. If the minor is not mature enough to give truly informed consent, the provider should not render treatment without the consent of the parent, guardian, or other authorized third party, unless the minor has an emergency medical condition, in which case consent is presumed.

A. Emancipated Minors

Emancipation for purposes of consenting to medical treatment may take various forms. Regardless of the method of emancipation,

[34] Cal. Fam. Code § 6911(a).
[35] *Id.*
[36] Tex. Fam. Code Ann. § 32.001(a)(6) (2004).
[37] Va. Code Ann. § 54.1-2969(A)(1) (2004).

emancipation broadly conveys on the minor the right to consent to or refuse medical treatment without the involvement of the minor's parent, guardian, or other third party. This is irrespective of whether the minor has reached the age of majority.[38]

A court order is not the only manner in which a minor can be emancipated for healthcare decisionmaking purposes. A minor may also be emancipated through marriage, active military service, or qualification as a self-sufficient minor. An emancipated minor may generally consent to any type of healthcare and is conveyed the same confidentiality rights as an adult, regardless of the manner in which the minor is emancipated.[39] A minor's parent or guardian is not financially responsible for payment for services consented to by an emancipated minor.[40] In most cases, a provider who seeks payment from the parent or guardian will violate the minor's confidentiality rights because submission of an invoice will constitute an unconsented disclosure of confidential information. Accordingly, with few exceptions, when treating an emancipated minor, the healthcare provider must deal with the minor as if she is an adult.

1. Emancipation by Court Order

Emancipation by court order extends not only to healthcare decisions but to other life functions as well (e.g., financial transactions).[41] Generally, a minor must be of a certain age to be emancipated. For example, California law provides that a minor must be at least fourteen years old to be emancipated by court order.[42] Nevada law provides that any minor who is sixteen years of age or older and who is married or who lives separate and apart from her parents may petition a court to be emancipated.[43]

Healthcare providers are often aware that an emancipated minor may consent to medical treatment, but providers are not always aware of how to document that a minor is, in fact, emancipated. Generally, the state's Department of Motor Vehicles issues an identification card to emancipated minors.[44] When a minor represents

[38] *See, e.g.*, CAL. FAM. CODE §§ 6920–6921 (2004).
[39] *See* 45 C.F.R. § 164.502(g)(3) (2004).
[40] *See, e.g.*, COLO. REV. STAT. § 13-22-103(2) (2004); KY. REV. STAT. ANN. § 214.185(3) (2004); MASS. GEN. LAWS ch. 112 § 12F (2004).
[41] However, emancipation may not extend to all life functions. For example, a minor emancipated by court order under Nevada law may not gamble or consume alcohol. NEV. REV. STAT. 129.130(3), 129.130(5) (2003).
[42] CAL. FAM. CODE § 7120(b)(1) (2004).
[43] NEV. REV. STAT. 129.080.
[44] *See* CAL. FAM. CODE § 7140.

to a healthcare provider that she is emancipated, the provider should ask for that identification card and include a copy of it in the minor's medical record. Failure of the minor to produce the identification card should raise suspicion that the minor may not be emancipated.

2. Emancipation by Marriage

Minors may also be emancipated by marriage.[45] In many states, a consenting minor may marry with the written consent of at least one parent or guardian and a court order granting permission to the minor to marry.[46]

When a minor marries, he is deemed emancipated for purposes of consenting to or refusing medical treatment.[47] That authority to consent to treatment generally persists even if the marriage is dissolved or if the minor's spouse dies.[48] Accordingly, a married, divorced, or widowed minor may consent to his own medical treatment.

When a minor claiming to be married, divorced, or widowed presents to a healthcare provider, the provider should obtain a copy of the minor's marriage certificate and include a copy in the minor's medical record prior to rendering treatment. Failure of the minor to produce proof of marriage should cause the provider to question whether the minor has lawful authority to give consent.

3. Emancipation by Active Military Service

A minor who is on active military duty has authority to consent to medical treatment.[49] To be on active military duty, a minor must be at least sixteen years old.[50] When treating a minor who is on active military duty, a healthcare provider should copy the minor's military identification card and include a copy in the minor's medical record.

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[45] *See id.* § 7002(a); KY. REV. STAT. ANN. § 214.185(3); ME. REV. STAT. ANN. tit. 22, § 1503 (2004); MD. CODE ANN., HEALTH–GEN. § 20-102(a)(1) (2004); MASS. GEN. LAWS ch. 112, § 12F; MONT. CODE ANN. § 41-1-402(2)(a) (2003); PA. STAT. ANN. tit. 35, § 10101 (2004); OKLA. STAT. ANN. tit. 63, § 2602(A)(1) (2004); R.I. GEN. LAWS § 23-4.6-1 (2003); VA. CODE ANN. § 54.1-2969(F) (2004).

[46] *See, e.g.,* CAL. FAM. CODE § 302.

[47] *See supra* note 45.

[48] *See, e.g.,* CAL. FAM. CODE § 7002(a); KY. REV. STAT. ANN. § 214.185(3); MASS. GEN. LAWS ch. 112 § 12F; MONT. CODE ANN. § 41-1-402(a); VA. CODE ANN. § 54.1-2969(F).

[49] *See* CAL. FAM. CODE § 7002(b); MASS. GEN. LAWS ch. 112, § 12F; ME. REV. STAT. ANN. tit. 22, § 1503.

[50] CAL. FAM. CODE § 6950; *see* U.S. Army, *About the Army, Enlisted Soldiers*, *at* www.goarmy.com/about/enlisted_soldier.jsp (last visited Sept. 8, 2004) (requiring an enlisted soldier to be at least seventeen years old).

4. Self-Sufficient and Homeless Minors

A minor may also be deemed emancipated for purposes of consenting to medical treatment if the healthcare provider determines that the minor is living independent of her parents or guardians. Minors who qualify to give consent under such statutes may either be homeless or self-sufficient. Unlike the other categories of emancipation, the healthcare provider makes the determination that a minor is self-sufficient or homeless and that determination extends to services rendered by that provider only.

Arizona law provides that a homeless minor may give consent to medical and surgical care to the same extent as a minor who has entered into a lawful marriage.[51] Arizona law defines a "homeless minor" as an individual less than eighteen years of age living apart from his or her parents and lacking a fixed and regular nighttime residence. This includes minors whose primary residence is a shelter, halfway house, or place not designed for and ordinarily not used for sleeping.[52]

Other states, such as Colorado and California, allow "self-sufficient" minors to consent to healthcare services.[53] Under both Colorado and California law, to be self-sufficient, a minor must:

a) be at least fifteen years of age;
b) live separate and apart from his or her parents or guardians (either with or without the parents' or guardians' consent); and
c) manage his or her own financial affairs, regardless of the minor's source of income.[54]

To determine that a minor is self-sufficient, a healthcare provider must obtain the minor's written affirmation of each of the foregoing criteria. While a provider may be able to objectively document the minor's age (e.g., by reference to a driver's license, school identification card, or birth certificate), the other criteria are more difficult to demonstrate. For example, there is no litmus test to determine whether a minor is living on her own or whether

[51] Ariz. Rev. Stat. § 44-132(A) (2004).
[52] *Id*. § 44-132(C).
[53] *See* Cal. Fam. Code § 6922(a) (2004); Colo. Rev. Stat. § 13-22-103(1) (2004); *see also* Me. Rev. Stat. Ann. tit. 22, § 1503 (requiring minor to live separately and independently for sixty days); Minn. Stat. Ann. § 144.341 (2004); Mont. Code Ann. § 41-1-402(2)(b) (2003); Okla. Stat. Ann. tit. 63, § 2602(A)(2) (2004).
[54] Cal. Fam. Code § 6922(a); Colo. Rev. Stat. § 13-22-103(1).

the minor is managing her own financial affairs. A provider may ask questions to help make those determinations, but it may be difficult to verify the truthfulness of the minor's answers. Furthermore, the statutes provide no guidance to make those determinations. For example, a provider may ask the minor whether she has a job or maintains a bank account, but an affirmative answer to either of those questions is insufficient to demonstrate financial independence. Similarly, a provider may ask questions to determine whether a minor lives separate and apart from her parents or guardians, but the circumstances under which a minor may live separate and apart vary greatly. For example, a minor may live with an adult caregiver with the permission of the minor's parent or guardian, or the minor may be a runaway with no permanent address. Under either scenario, the minor is living separate and apart for purposes of either the California or the Colorado statute. In light of the great variability of facts that might determine that a minor is self-sufficient, a provider need only make a good faith effort to determine whether the minor meets the statutory criteria, and the provider should thoroughly document such efforts.[55]

Unlike Colorado law, California law distinguishes treatment of a self-sufficient minor from treatment of other emancipated minors by providing that a healthcare provider may, but is not required to, inform the minor's parent or guardian of treatment needed by or rendered to the minor if the minor gives the provider information as to the whereabouts of the minor's parent or guardian.[56] Under that circumstance, the provider does not need the minor's consent to contact the minor's parent; however, there are no objective legal criteria for determining when a minor's parents or guardians should be contacted. Accordingly, providers should make that determination in the minor's best interest, considering the minor's physical and mental condition and her relationship with the parents or guardians.

B. Minors' Consent to Diagnosis and Treatment of Specific Conditions

Most state legislatures recognize the rights of unemancipated minors to consent to specific types of medical treatment without the involvement of the minor's parent, guardian, or other third party.

[55] *See* Colo. Rev. Stat. § 13-22-103(2) (requiring "good faith" reliance); *see also* Ala. Code § 22-8-7 (2004); Ky. Rev. Stat. Ann. § 214.185(5) (2004); Mass. Gen. Laws ch. 112, § 12F (2004); Minn. Stat. Ann. § 144.345 (2004); Or. Rev. Stat. § 109.685 (2003).

[56] Cal. Fam. Code § 6922(c). *Contra* Colo. Rev. Stat. § 13-22-103.

Those statutory exceptions include allowing a minor to consent to: certain mental health services; diagnosis and treatment of drug or alcohol abuse; diagnosis and treatment of infectious, contagious, or communicable diseases; diagnosis and treatment for sexual assault; and prevention or treatment of pregnancy.

1. Mental Health Treatment and Counseling Services

State laws allow a minor patient who meets a minimum age requirement to consent to mental health services.[57] Such laws are generally justified because the minor presents a danger to self or others.[58] California, Florida, and Ohio provide good examples of the varying state laws governing consent to mental health services.

To consent to mental health treatment or counseling services, California law provides that a minor must be at least twelve years of age and either be a threat to self or others or be the alleged victim of child abuse or incest.[59] The minor may only lawfully consent to outpatient treatment and counseling services and to temporary or emergency residential shelter services.[60] Under California law, a minor may not consent to inpatient psychiatric treatment, administration of psychotropic drugs, psychosurgery, or convulsive therapy.[61]

State-Statutory Scheme

[57] *See* Ala. Code § 22-8-4 (2004) (14 years or older); Cal. Fam. Code § 6924(b) (12 years or older); Colo. Rev. Stat. Ann. § 13-22-103(1) (15 years or older if living apart from parent or guardian); Fla. Stat. Ann. § 394.4784(1)-(2) (2003) (13 years or older); Ky. Rev. Stat. Ann. § 214.185(2) (16 years or older); Mich. Comp. Laws Ann. § 330.1707(1) (2004) (14 years or older); Miss. Code Ann. § 41-41-14(1) (2004) (15 years or older); Mont. Code Ann. § 53-21-112(2) (2003) (16 years or older); Ohio Rev. Code Ann. § 5122.04(A) (2004) (14 years or older); Or. Rev. Stat. § 109.675(1) (14 years or older); Va. Code Ann. § 54.1-2969(E)(4) (2004) (14 years or older); Wash. Rev. Code Ann. § 71.34.042(1) (2004) (13 years or older); Wis. Stat. Ann. § 51.14(3)(a) (2003), *amended by* 2003 Wis. Legis. Serv. 326 (West) (14 years or older).

[58] *See generally* Cal. Fam. Code § 6924(b)(2) (noting circumstances in which a minor of twelve years or older may consent to mental health treatment or counseling).

[59] *Id.* § 6924(b)(2). California requires that two conditions be satisfied. The healthcare professional must believe the minor to be mature enough to participate in the mental health services and believe that the minor presents a danger to self or others. *Id.*

[60] *Id.* §§ 6924(a)(3)(A), 6924(b).

[61] *Id.* §§ 6924(a)(1), 6924(f); s*ee also* Mich. Comp. Laws Ann. § 330.1707(1) (disallowing a minor of fourteen years or older to consent to inpatient mental health services or the use of psychotropic drugs). *But see.* Tex. Health & Safety Code Ann. § 572.001(a) (2004) (allowing a minor sixteen years or older, or a married younger minor, to consent to inpatient mental health services); D.C. Code Ann. § 7-1231.14(c)(2) (2004) (permitting a minor 16 years or older to consent to psychotropic drugs); N.Y. Mental Hyg. Law § 33.21(e)(2) (2004) (permitting a minor sixteen years or older to consent to psychotropic drugs).

California law requires the professional providing the mental health treatment to involve the minor's parent or guardian in the treatment unless the professional providing treatment deems it inappropriate.[62] The professional providing treatment to the minor must record "whether and when the [professional] attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful" or the professional's reasoning as to why such an attempt would be inappropriate.[63] With regard to residential shelter services, the professional offering such services must make his best effort to notify the minor's parent or guardian of the services provided.[64]

In Florida, a minor must be at least thirteen years old and experience "an emotional crisis to such degree that he or she perceives the need for professional assistance" in order to consent to mental health diagnostic, evaluation, or intervention services.[65] Like California law, Florida law precludes outpatient services from including prescription of medications,[66] but Florida law allows a minor to consent to inpatient mental health treatment.[67] Florida and California law also differ in that Florida law limits treatment to two visits during any one-week period without obtaining parental consent.[68] Such number-of-visit restrictions are not unusual.

Similar to Florida law, Ohio law allows a minor to consent to outpatient services, excluding medications,[69] but limits services to six sessions or thirty days, which ever is less.[70] Under both Florida and Ohio law, parental consent must be obtained to continue providing services in excess of the statutory limit.[71] Parental consent would not be practical where a minor remains in distress, particularly if the minor's parent is the source of the distress. Thus, Ohio's bright-line cap of six sessions or thirty days raises more significant patient care issues than Florida's law, which only restricts the frequency of visits and not the duration. Nonetheless, both the Florida and Ohio laws are examples of state legislatures attempting to balance the confidentiality and access rights of minors against the need for adult involvement in the healthcare decisionmaking process.

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[62] Cal. Fam. Code § 6924(d).
[63] *Id.*
[64] *Id.* § 6924(c).
[65] Fla. Stat. Ann. § 394.4784(1) (2003).
[66] *Id.* § 394.4784(2).
[67] *Id.* § 394.4784(1).
[68] *Id.*
[69] Ohio Rev. Code Ann. § 5122.04(A) (2004).
[70] *Id.* § 5122.04(B).
[71] *Id.*; Fla. Stat. Ann. § 394.4784(2).

2. Drug and Alcohol Abuse Treatment and Counseling

A separate legal basis allows a minor to consent to medical treatment and counseling services related to the diagnosis and treatment of a drug or alcohol related problem.[72] Some states, such as New Jersey, allow a minor, regardless of age, to consent to treatment for drug or alcohol dependency.[73] New Jersey law allows a minor to consent to inpatient or outpatient treatment and specifically provides that such voluntary consent is confidential from the minor's parent or guardian, unless otherwise required by law.[74]

In contrast to New Jersey law, California law requires that a minor be at least twelve years of age to consent to drug or alcohol treatment.[75] Furthermore, California law requires that when a minor consents to treatment for a drug or alcohol related problem, the treatment plan must involve the minor's parent or guardian if determined appropriate by the healthcare practitioner or treatment facility.[76] The practitioner must indicate in the minor's medical record "whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt … was successful or unsuccessful."[77] If the practitioner determines that the minor's parent or guardian should not be contacted, then the reasons for that determination must be stated in the minor's medical record.[78] The minor's parent or guardian is responsible for payment of the minor's treatment only if the parent or guard-

[72] *See* ALA. CODE § 22-8-6 (2004); ARIZ. REV. STAT. ANN. § 44-133.01 (2004); CAL. FAM. CODE. § 6929(b) (2004), *amended by* 2004 Cal. Legis. Serv. 2182 (West); COLO. REV. STAT. ANN. § 13-22-102 (2004); CONN. GEN. STAT. ANN. § 17a-688(d) (2004); FLA. STAT. ANN. § 397.601(4)(a) (2003); GA. CODE ANN. § 37-7-8(b) (2004); HAW. REV. STAT. ANN. § 577-26(e) (2003); 410 ILL. COMP. STAT. ANN. 210/4 (2004); IND. CODE ANN. § 12-23-12-1 (2004); KAN. STAT. ANN. § 65-2892a (2003); KY. REV. STAT. ANN. § 222.441(1) (2004); LA. REV. STAT. ANN. § 1096(A) (2004); ME. REV. STAT. ANN. tit. 22, § 1502 (2004); MD. CODE ANN., HEALTH–GEN. I § 20-102(c)(1)–(2) (2004); MASS. GEN. LAWS ANN. ch. 112, § 12E (2004); MICH. COMP. LAWS ANN. § 333.6121(1) (2004); MINN. STAT. ANN. § 144.343(1) (2004), *amended by* 2004 Minn. Sess. Law Serv. 1745 (West); MISS. CODE ANN. § 41-41-14(1) (2003); NEB. REV. STAT. § 71-5041 (2003), *repealed by* 2004 Neb. Laws 1083; NEV. REV. STAT. ANN. 129.050(1) (2004); N.J. STAT. ANN. § 9:17A-4 (2004); OHIO REV. CODE ANN. § 3719.012(A) OKLA. STAT. ANN. tit. 43A, § 9-101(A) (2004); PA. STAT. ANN. tit. 71, § 1690.112 (2004); VT. STAT. ANN. tit. 18, § 4226(a) (2003); VA. CODE ANN. § 54.1-2969(E)(3) (2004); W.VA. CODE ANN. § 60A-5-504 (e) (2004); WIS. STAT. ANN. § 51.47(1) (2003).

[73] N.J. STAT. ANN. § 9:17A-4.

[74] *Id.*

[75] CAL. FAM. CODE § 6929(b) (2004), *amended by* 2004 Cal. Legis. Serv. 2182 (West).

[76] *Id.* § 6929(c).

[77] *Id.*

[78] *Id.*

ian participated in a counseling program or otherwise agreed to assume that obligation.[79]

3. Infectious, Contagious, or Communicable Diseases

State legislatures have provided minor patients with the right to consent to treatment of certain infectious and/or sexually transmitted diseases without the involvement of a parent or guardian.[80] For example, Ohio and New Jersey law both authorize a minor of any age to consent to diagnosis and treatment of any "venereal disease" by a licensed physician.[81] Similarly, Virginia law grants a minor, regardless of age, the authority to consent to healthcare services necessary to diagnose or treat any venereal, infectious, or contagious disease that must be reported to the Virginia State Board of Health.[82] California law authorizes "[a] minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease [to] consent to medical care related to the diagnosis or treatment of the disease."[83] Similar to Virginia law, California law defines an "infectious, contagious, or communicable disease" as a sexually transmitted disease or any disease or condition that is required by law or regulation to be reported to the local health officer.[84] Reportable diseases include conditions ranging from food-borne illnesses (e.g., botulism and paralytic shellfish poisoning) to tropical diseases (e.g., malaria and dengue fever).[85]

[79] *Id.* § 6929(d).

[80] *See* Ala. Code § 22-11A-19 (2004); Ark. Code Ann. § 20-16-508(a)(1) (2003); Colo. Rev. Stat. Ann. § 25-4-402(4) (2002); Conn. Gen. Stat. Ann. § 19a-216(a) (2004); Del. Code Ann. tit. 13, § 710(a) (2004); Fla. Stat. Ann. § 384.30(1) (2003); Ga. Code Ann. § 31-17-7(a) (2004); Haw. Rev. Stat. Ann. § 577A-2 (2003); Idaho Code § 39-3801 (2003); 410 Ill. Comp. Stat. Ann. 210/4 (2004); Ky. Rev. Stat. Ann. § 214.185(1) (2004); La. Rev. Stat. Ann. Tit. 40, § 1065.1(A) (2004); Me. Rev. Stat. Ann. tit. 22, § 1823 (2004); Md. Code Ann., Health-Gen. I § 20-102(c)(3) (2004); Mich. Comp. Laws Ann. § 333.5127(1) (2004); Minn. Stat. Ann. § 144.343(1) (2004), *amended by* 2004 Minn. Sess. Law Serv. 1745 (West); Miss. Code Ann. § 41-41-13 (2004); Mo. Ann. Stat. § 431.061(4)(b) (2004); Mont. Code Ann. § 41-1-402(2)(c) (2004); N.J. Stat. Ann. § 9:17A-4 (2004); Ohio Rev. Code Ann. § 3709.241 (2004); Okla. Stat. Ann. tit. 63, § 1-532.1 (2004); Or. Rev. Stat. § 109.610(1) (2003); Pa. Stat. Ann. tit. 35, § 521.14a (2004); S.D. Codified Laws § 34-23-16 (2004); Utah Code Ann. § 26-6-18(1) (2004); Vt. Stat. Ann. tit. 18, § 4226(a) (2003); Va. Code Ann. § 54.1-2969(E)(1) (2004); W.Va. Code Ann. § 16-4-10 (2004).

[81] Ohio Rev. Code Ann. § 3709.241; N.J. Stat. Ann. § 9:17A-4.

[82] Va. Code Ann. § 54.1-2969(E)(1).

[83] Cal. Fam. Code § 6926(a) (2004).

[84] *Id.*

[85] Cal. Code Regs. tit. 17, § 2500(j) (2004).

This basis for allowing a minor to consent to treatment serves two primary purposes. First, it serves a public health purpose by allowing minors to consent to treatment of diseases that may pose a threat to others. Allowing such consent may speed the treatment process and help to contain a possible epidemic.[86] Second, allowing a minor to consent to treatment, particularly of sexually transmitted diseases, increases the likelihood that the minor will seek treatment. Health professionals generally recognize that providing confidential services increases the likelihood that minors will seek treatment.[87]

The scope of this statutory authorization generally includes allowing a minor to consent to HIV testing.[88] As with consent to other types of treatment, the minor must be able to understand and appreciate the consequences of being tested for HIV. Accordingly, when a minor who meets the applicable minimum age requirement and is mature enough to give informed consent initiates the HIV testing process, the results of the test must be held confidential from the minor's parent or guardian.[89]

4. Sexual Assault

State-Statutory Scheme

"A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence."[90] "Sexual assault" means rape, sodomy, or oral copulation.[91] This authority is generally conveyed to minors regardless of age.[92]

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[86] *See* Rhonda Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 Am. J.L. & Med., 409, 416 (2002).

[87] *See* Am. Med. Ass'n, American Medical Association Policy, H-60.965 Confidential Health Services for Adolescents, *available at* tinyurl.com/4z6qs (last visited Oct. 20, 2004) ("The AMA … reaffirms that confidential care for adolescents is critical to improving their health.").

[88] Mich. Comp. Laws Ann. § 333.5127(1) (2004). *Cf.* Am. Med. Ass'n, American Medical Association Policy, H-60.958 Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment, *available at* tinyurl.com/6narg (last visited Oct. 20, 2004) (encouraging legislation to "decrease the spread of sexually transmitted diseases (STDs) in minors, specifically by allowing minors to consent for the means of prevention, diagnosis and treatment of STDs, including AIDS.").

[89] 45 C.F.R. § 164.502(g)(3)(ii) (2004).

[90] Cal. Fam. Code § 6928(b) (2004); *see also* Colo. Rev. Stat. Ann. § 13-22-106(1) (2004); 410 Ill. Comp. Stat. Ann. 210/3(b) (2004); Me. Rev. Stat. Ann. tit. 22, § 1823 (2004); Md. Code Ann., Health-Gen. I § 20-102(c)(6)–(7) (2004); N.J. Stat. Ann. § 9:17A-4 (2004); Ohio Rev. Code Ann. § 2907.29 (2004).

[91] Cal. Fam. Code § 6928(a); Cal. Penal Code §§ 261(a), 286(a), 288a(a) (2003).

[92] *See generally* Cal. Fam. Code § 6928.

Both New Jersey and California law require that a healthcare provider treating a minor for sexual assault attempt to contact the minor's parent or guardian.[93] California law requires that the practitioner note in the minor's medical record the date and time of the attempted contact and whether the attempt was successful or unsuccessful.[94] Both states, however, provide exceptions to the parental notification requirement. In New Jersey, a practitioner is not required to contact the minor's parent or guardian if the practitioner believes that such contact is not in the minor's best interest.[95] California law provides that the practitioner is not required to contact the parent or guardian if the practitioner "reasonably believes that the minor's parent or guardian committed the sexual assault on the minor."[96]

On this topic, California law contains an additional provision that can complicate matters for healthcare practitioners. In the same statutory enactment in which the California legislature allowed a minor, regardless of age, to consent to diagnosis and treatment related to a sexual assault, the legislature enacted a separate statutory provision allowing a minor who is at least twelve years old to consent to medical care related to the diagnosis or treatment of a condition resulting from an alleged rape.[97] Those two statutory provisions are not consistent with each other insofar as Section 6927 (which allows a minor who is at least twelve years of age to consent to treatment of conditions resulting from alleged rape) does not contain the same language as Section 6928 (which allows any minor regardless of age to consent to treatment of a condition resulting from a sexual assault, including rape) that requires the practitioner to attempt to contact the minor's parent or guardian.[98] Accordingly, it is not clear whether the California legislature intended for a minor at least twelve years of age who is an alleged rape victim to have a confidentiality right that prevents the practitioner from contacting the minor's parent or guardian. Absent an express legislative intent or judicial interpretation, the statutes should be read as overlapping rather than conflicting, and the parental notification requirement contained in Section 6928 should be complied with regardless of the age of the alleged rape victim. This legislative oversight is an example of how specific state laws do not always provide clearer guidance.

[93] N.J. Stat. Ann. § 9:17A-4; Cal. Fam. Code § 6928(c).
[94] Cal. Fam. Code § 6928(c).
[95] N.J. Stat. Ann. § 9:17A-4.
[96] Cal. Fam. Code § 6928(c); *see* Cal. Penal Code § 11166(a) (2002) (requiring that a professional report to a law enforcement agency any suspected victim of child abuse or neglect).
[97] Cal. Fam. Code § 6927.
[98] *Id.* §§ 6927, 6928.

5. Pregnancy-Related Services

State laws also generally permit a minor to consent to pregnancy-related health services, including prevention and treatment of pregnancy.[99] For purposes of pregnancy-related treatment, some states deem pregnant minors to be emancipated for purposes of healthcare decisionmaking, while other states limit the pregnant minor's authority to give consent to conditions that are directly related to the pregnancy. For example, Pennsylvania law provides that a minor who is or has been pregnant has the same broad consent rights as a minor who marries or achieves the age of majority.[100] That approach allows a minor to consent to care for her child and herself after she gives birth. Similarly, Nevada law expressly allows a minor who has borne a child to consent to treatment for her child and herself.[101]

In contrast to Pennsylvania and Nevada law, California law does not provide that a pregnant minor is emancipated by virtue of being pregnant or giving birth. California law is unusual in that a pregnant minor may only consent to pregnancy-related treatment and, absent some other grounds, cannot consent to her own general medical treatment. Additionally, once her child is born, the minor has legal authority to consent to treatment for her child; however, she does not, by virtue of becoming a parent, have lawful authority to consent to her own treatment.

Similarly, in Virginia where a pregnant minor is not deemed fully emancipated for healthcare decisionmaking, the law provides that the minor mother of a child is deemed an adult for purposes of consenting to treatment for her child.[102] Virginia law does not, however, expressly allow a minor child who is a mother to consent to her own treatment after she has given birth.[103]

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[99] *See* ALASKA STAT. § 25.20.025(a)(4) (2003); CAL. FAM. CODE § 6925(a); DEL. CODE ANN. tit 13, § 710(a); FLA. STAT. ANN. § 743.065(1) (2003); KAN. STAT. ANN. § 38-123 (2003); KY. REV. STAT. ANN. § 214.185(1) (2004); MD. CODE ANN., HEALTH –GEN. I § 20-102(c)(4) (2004); MASS. GEN. LAWS ANN. ch. 112, § 12F (2004); MINN. STAT. ANN. § 144.343(1) (2003), *amended by* 2004 Minn. Sess. Law Serv. 1745 (West); MO. ANN. STAT. § 431.061(4)(a) (2004); MONT. CODE ANN. § 41-1-402(2)(c) (2004); OKLA. STAT. ANN. tit. 63, § 2602(3) (2004); PA. CONS. STAT. ANN. tit. 35, § 10103 (2004); VA. CODE ANN. § 54.1-2969(E)(2) (2004).

[100] PA. CONS. STAT. ANN. tit. 35, § 10101.

[101] NEV. REV. STAT. ANN. § 129.030(1)(c) (2003).

[102] VA. CODE ANN. § 54.1-2969(G).

[103] *Id.* ("A pregnant minor shall be deemed an adult for the sole purpose of giving consent for herself and her child . . . relating to the delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child.")

State laws governing a minor's right to abortion are particularly complicated because of varying judicial intervention. For example, the California Supreme Court held in 1971 that a minor who convinces a healthcare professional that "she has the requisite understanding and maturity to give an informed consent" may "seek [a] therapeutic [abortion] without parental consent."[104] Despite that judicial precedent, the California legislature subsequently attempted to require parental consent.[105] The California Supreme Court, however, intervened and held the parental consent statute to be an unconstitutional invasion of a minor's right of privacy under the state constitution.[106] Consequently, the statutory parental consent requirement has not been enforced, even though it has not been repealed.

It is important for healthcare practitioners to keep in mind that, while case law recognizes the privacy rights of minors, it does not override the need for a minor's consent to an abortion to be truly informed in order to be legally effective. In many instances, a minor under twelve years of age is generally presumed to lack the ability to give informed consent.[107] Accordingly, healthcare practitioners are well advised to give heightened scrutiny to the ability of minor patients under twelve years of age to understand and appreciate the nature of an abortion, the alternatives, and the corresponding risks and benefits. If the minor, regardless of age, is not mature enough to give informed consent, then the healthcare practitioner should assess whether it is in the minor's best interest to notify the minor's parent or guardian. The practitioner, however, does not have lawful authority to contact the minor's parent or guardian without the minor's consent and to do so may violate state and federal laws protecting the confidentiality of medical information.

In recognition of the difficult issues that healthcare providers face when minors seek abortions without parental involvement, the American Medical Association (AMA) has issued a policy statement addressing the issue. While lacking the force of law, the AMA policy statement provides valuable guidance to physicians who face difficult treatment decisions. The policy statement provides that:

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[104] Ballard v. Anderson, 4 Cal. 3d 873, 883–84 (1971).

[105] Cal. Health & Safety Code § 123450(a) (2004); Cal. Fam. Code § 6925(b)(2) (2004).

[106] Am. Acad. of Pediatrics v. Lungren, 16 Cal. 4th 307, 359 (1997).

[107] No California statute containing a minimum age threshold sets that minimum age below twelve. *See, e.g.*, Cal. Fam. Code § 6924(b); Cal. Fam. Code § 6926(a); Cal. Fam. Code § 6929(b) (2003), *amended by* 2004 Cal. Legis. Serv. 2182 (2004).

> Physicians should strongly encourage minors to discuss their pregnancy with their parents. Physicians should explain how parental involvement can be helpful and that parents are generally very understanding and supportive. If a minor expresses concerns about parental involvement, the physician should ensure that the minor's reluctance is not based on any misperceptions about the likely consequences of parental involvement.[108]

However, the AMA further advises that:

> Physicians should not feel or be compelled to require minors to involve their parents before deciding whether to undergo an abortion. The patient, even an adolescent, generally must decide whether, on balance, parental involvement is advisable.[109]

In the event that a minor chooses not to consult with her parents, the AMA recommends that physicians urge the minor to seek the counsel of other adults whom she trusts, "including professional counselors, relatives, friends, teachers, or the clergy."[110]

Accordingly, physicians have a great deal of discretion when offering abortion services to minors. Physicians must exercise caution to appropriately balance the rights of unemancipated, yet mature, minors to obtain confidential services with the need for minors who lack the maturity level required to give informed consent to obtain appropriate guidance in the decisionmaking process.

IV. Conclusion

Healthcare providers face complicated rules and exceptions governing a minor's consent to medical treatment. While legitimate public policy concerns underpin those rules and exceptions, providers must exercise caution when treating minor patients to ensure that they obtain and document informed consent from the appropriate, lawfully authorized person, whether that is the minor,

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[108] Am. Med. Ass'n, American Medical Association Code of Medical Ethics, E-2.015 Mandatory Parental Consent to Abortion, *available at* www.ama-assn.org/ama/pub/category/8386.html (last visited Sept. 11, 2004).

[109] *Id.*

[110] *Id.*

the minor's parent or guardian, or some other authorized individual. The importance of obtaining and documenting appropriate informed consent is heightened by the fact that confidentiality rights generally attach to the individual who is authorized by law to consent to treatment. Furthermore, providers must be diligent to determine that, when a minor gives informed consent, the minor is mature enough to appreciate the nature of the treatment, the risks and benefits, and alternatives so that the consent given is truly informed. Understanding the applicable statutory scheme is essential to ensuring legal compliance, protecting against liability, and ensuring that minors receive the best care possible.